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THE HISTORY OF PAIN AND THE MENSTRUAL HISTORY OF EXTRAUTERINE PREGNANCY.[1]

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IT has become possible in the last ten years for experts to make a positive diagnosis in the majority of cases of tubal pregnancy before the sac has ruptured, and I find it by no means rare for the general practitioner to have made such a diagnosis correctly before summoning a consultant. Many women, however, suffering from a tubal pregnancy are treated to-day for a miscarriage; and the minds of all specialists cannot be quite clear on the signs of ectopic gestation when one reads in an English monograph on the subject that pain is not a symptom of the condition, when he sees this statement copied in a recent text book of prominence, and encounters the curious assertion in one of the latest English works on gynecology that a woman with pelvic pain and amenorrhea may be supposed to have an extrauterine pregnancy in the absence of a history pointing to an old pyosalpinx or to other pelvic inflammation.

As a matter of fact, there are three cardinal symptoms of ectopic gestation: pain, characteristic in nature, manner of occurrence, and situation; irregularity of menstruation, often with the discharge of what the patient calls "pieces of flesh" (decidua); and these physical signs: for the first two, three, or four weeks a small swelling in the tube, no bigger than the end joint of one's thumb, and unadherent; later an exquisitely sensitive mass fixed in the pelvis by thick, velvety adhesions.[2]

Of the three cardinal symptoms the pain has been most helpful to me in making a diagnosis. I have in my case books the full histories of twenty-two extrauterine pregnancies. This is not my total experience, for I have omitted all doubtful records

[1] Read before the Section on Gynecology, College of Physicians of Philadelphia, February 17, 1898.

[2] These adhesions are extremely vascular, are often the source of the intraperitoneal bleeding, and, it seems to me, contribute to the nutrition of the ovum after the manner of an early stage of the deciduous membrane within the womb in normal pregnancy.

in which an embryo was not found or a microscopic examination was not made, and I have unfortunately failed to obtain the histories of some of my cases. This is not, however, surprising. It is obviously impossible to secure a history of every case. Called to a woman who has been bleeding internally for some time, a physician cannot torture the moribund patient and distracted family by a cross-examination. Numerically scanty as it is,[1] this recorded experience has been most instructive to me, and I find no single item in these histories so distinctive as the history of pain.

Glancing over the following table (Table I.), one sees plainly that the pain of extrauterine pregnancy has characteristic peculiarities and is distinctive. It might be defined with some

TABLE I.—PAROXYSMS OF PAIN.

Time of first occurrence after last normal menstruation.	Character.	Situation.	Repetition of paroxysms.	Systemic effect.
Two calendar months.	Two months after last sickness rupture occurred, and patient died in twelve hours without previous history of pain. Treated for miscarriage while dying from internal hemorrhage.			
Two months and ten days. First paroxysm of pain day after cessation of a continuous flow lasting twenty-seven days, and beginning ten days later than the period for a normal menstruation.	Violent pain appearing first at stool	In the rectum, extending up both sides of abdomen.	Several daily for two weeks.	Face blanched; vision obscured; tendency to faint.
	Treated for miscarriage by a professed specialist in gynecology.			
First paroxysm in the midst of a four weeks' flow that had begun at the normal time for a menstrual period.	Sudden violent abdominal pain while at stool.	Indefinite; lower abdomen.	Several times a day for two weeks.	Syncope at first attack; repeated loss of consciousness for the first week.

[1] Compared with a collective experience. For a single individual this experience is not small. One sees in journals occasionally the loose statement that an operator has had a "hundred cases or more" of extrauterine pregnancy. An investigation of his case books would probably reduce this number by more than three-fourths.

TABLE I.—PAROXYSMS OF PAIN (*Continued*).

Time of first occurrence after last normal menstruation.	Character.	Situation.	Repetition of paroxysms.	Systemic effect.
There was no cessation of menstruation First paroxysm occurred two and a half months after first exposure to illegitimate impregnation.	Sharp, stabbing	Right groin...	Several.....	Suffering completely disabled her, but she did not faint.
Within a day or two after last normal menstruation	Sharp, agonizing.	Back and front in the middle line of the lower abdomen, but extending down the right leg.	Repeated. A particularly severe paroxysm, with the period delayed ten days.	Completely disabled and bedridden.
Two weeks after last normal menstruation.	Severe abdominal pain.	In lower abdomen; not definitely located.	Two severe; many less violent.	Completely disabled and forced to go to bed.
Two months from last sickness.	Sharp, stabbing; anguish.	Lower abdomen and down right leg	Several.....	Hysteria, first time in her life.
Three and two-third months.	Frightful agony.	Left lower abdomen, extending up to epigastrium.	One	Shock, subnormal temperature; hollow cheeks; sunken eyes; pulse not bad.
Five and one-half weeks from last menses	Violent shooting pains.	Lower abdomen, extending to epigastrium.	Three in four months.	Semi-unconscious; cold sweat; vomiting.
Three lunar months.	Dreadfully sharp, following a blow on the abdomen.	Indefinite; in abdomen; down right leg.	Several in a week.	Syncope followed by vomiting.
		Treated for miscarriage.		
Three lunar months short four days.	Violent, excruciating.	In left groin..	Three in twelve days.	Syncope followed by vomiting.
		Treated for miscarriage.		
Seven weeks..	Fearful abdominal pain.	On right side; down right leg.	Two in two months. The last occurring every day for three weeks.	Syncope in first and "sinking spells" in subsequent attacks.
Two weeks...	Great pain in lower abdomen.	Lower abdomen.	About twenty in a month; intervals completely free.	Cold sweat; no syncope or tendency to faint.

TABLE I.—PAROXYSMS OF PAIN (*Continued*).

Time of first occurrence after last normal menstruation.	Character.	Situation.	Repetition of paroxysms.	Systemic effect.
Six weeks....	Severe abdominal pains.	Not definitely located.	One in two days; another three weeks later.	Confined to bed for six weeks with pain, fever, bloated abdomen.
Seven weeks..	Fearful abdominal pain.	Not definitely located.	Again in ten days, and thereafter daily for three weeks.	Syncope and repeated "sinking spells."
		Treated for miscarriage.		
Two calendar months.	Agonizing pain	In bottom of stomach.	Repeated, confining her to bed for three weeks.	Syncope followed by delirium.
		Treated for miscarriage		
Two months..	Sharp, stabbing.	In right groin.	Repeated during a period of six weeks.	No history of syncope, sweat, or faintness
Two and one-half months.	Severe abdominal pain.	Not definitely located.	Repeated in two periods of three weeks.	Disabled and confined to bed.
Two weeks...	Severe abdominal.	Not definitely located; in lower abdomen.	Many attacks in a period of two weeks	Disabled and confined to bed.
Eight weeks	Sharp, agonizing in abdomen.	Not definitely located.	Repeated attacks in a period of four months.	Disabled and bedridden; syncope in first attack.
Seven and one-half weeks.	Sudden, intense pain.	In right groin.	Not another for three months.	Syncope followed by nausea and vomiting.
After a continuous flow lasting six weeks and beginning at a normal time for a menstrual period.	Severe abdominal.	Not located...	None.....	Dropped to the ground in dead faint. Carried to the hospital and operated on immediately.

degree of precision as a pain described by the patient in strongest terms; occurring in paroxysms with intervals free from suffering; appearing at any time from a few days to months after a normal menstruation; situated often in one groin, though frequently indefinitely referred to the lower abdomen; extending down one leg or up to the epigastrium; and a pain so severe as to occasion profound systemic disturbance—syncope followed

by nausea and vomiting, a cold sweat, hysterical outbreaks, complete disability, and every appearance of excessive shock.

These systemic symptoms, be it understood, are the result often of the intolerable agony and do not necessarily indicate rupture of the sac and internal bleeding. In the majority of my operations there is not enough blood in the pelvis to account for the systemic symptoms, and I often find no intraperitoneal bleeding at all until the extremely vascular and peculiar adhesions already referred to are torn in the enucleation and delivery of the sac.

TABLE II.—MENSTRUAL HISTORY.

Cessation of menses.	Return of flow.	Continuance.	Discharge of decidua.
For two months..	None.....	None.....	None.
	Patient died from rupture in a few hours at second month.		
For thirty-eight days.	In thirty-eight days.	Lasted twenty-seven days.	None.
None.....	Menstruation regular, except that one period continued a month.	One period continued a month, the flow persisting at time of operation.	None.
None	Regularly every month; no cessation of menstruation.	The normal length of time three to five days; fetus, two and one-half months, removed at time of operation.	None.
For thirty-eight days.	On thirty-eighth day; did not reappear at time for next period.	None.....	At the appearance of the delayed menstruation.
None; a flow of blood occurred three weeks after last normal period.	In two weeks after discharge noted in preceding column.	Two days..... ...	At the fifth week after last normal menstruation; in the second flow of blood.
Two and one-half months.	In two and one-half months.	For three weeks..	None; rupture occurred at third month; death in seven hours.
None.....	Two weeks after last normal period.	For two weeks....	None.
For eight weeks..	In eight weeks....	For four months..	None.
For fifty-three days	In fifty-three days. (At preceding menstrual period there had been a few drops of blood.)	For two weeks....	At the third month.
None.....	In four weeks...	For six weeks.....	None.
Missed two periods.	In two and one-half months.	Twelve days.....	On third or fourth day of flow.

TABLE II. (*Continued*).

Cessation of menses.	Return of flow.	Continuance.	Discharge of decidua.
Missed one period; returned ten days late.	In thirty-eight days.	Lasted one day; returned in ten days; slight discharge for three weeks, then a more profuse flow lasting almost continuously for three and one-half months.	None.
For three lunar months.	None.....	Rupture occurred with profuse internal bleeding; no discharges till five days after operation, three and one-half months after cessation of menses	
Twelve days late; cessation of menses for forty days from last normal period.	In twelve days; then in eleven days, and again in a lunar month	Lasted one day; then two days; and on third reappearance, three weeks.	On the first day of third reappearance.
Three weeks late.	In seven weeks; again in a week; again in three weeks; again in a week.	No long continued flow.	On the third day of first return of flow.
None; a flow appeared fifteen days after cessation of last normal sickness.	Continued for a month.		None.
For six weeks; two weeks late.	In six weeks; again in seven weeks.	For a week; discharge continuing at time of operation.	None.
For seven weeks; three weeks late.	In seven weeks; again in four weeks; again in forty days	Last menstrual discharge continued a week and was very profuse.	On the first day of the first return of the flow.
For two calendar months.	In two months....	Lasted three weeks.	On the first day of return of flow
Two and one-half months.	In two and one-half months.	Six weeks.....	After four weeks of continuous flow.
Missed three periods.	Three months and three weeks.	Six weeks	On second or third day of flow.

Turning next to the tabular statement in regard to menstruation, one is struck with the fact that the characteristic menstrual history of extrauterine pregnancy is one of irregularity and often not of cessation at all. In six of my cases, or twenty-seven per cent, there was no cessation of menstruation, and in

four more a menstrual period was only delayed ten to twelve days.

Prolonged uterine bleeding, on the other hand, preceded or followed by the discharge of decidua, is the almost universal rule at some period in the history of a tubal pregnancy.

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